

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4093AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2009
NAME OF PROVIDER OR SUPPLIER JCR HOME CARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7160 DARBY AVENUE LAS VEGAS, NV 89117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28384 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 11/2/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was four. Complaint #NV 00023352 was substantiated. See Tag Y175. Complaint #NV 00023443 was substantiated without deficiency. The following deficiencies were identified:	Y 000		
Y 175 SS=D	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Surveyor: 28384 Based on observations and interviews on	Y 175		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 175	<p>Continued From page 1</p> <p>11/2/09, the facility failed to keep the facility free of obstacles and hazards that impede free movement by 4 of 4 residents.</p> <p>Findings include:</p> <p>The facility had one small dog inside the facility and three small dogs running loose in the back yard. The surveyor observed the dog's demonstrating a high degree of energy running around the yard. When the surveyor entered the back yard the dogs jumped up placing their front legs onto the legs of the surveyor.</p> <p>According to interview with Employee #1 the dogs come into the home in the evening and sleep with the caregiver.</p> <p>During an interview with Resident #3 the dog that was in the house approached the resident and jumped around the resident's legs in an attention-seeking manner. Resident #3 stated she did not like the dog to bother her and waved her arms at the dog to get him to leave. During a telephone interview with a resident's family member the relative reported that the dogs were very active and he worried that his mother would trip on the dogs.</p> <p>Severity 2 Scope 1</p>	Y 175			
Y 923 SS=F	<p>449.2748(3)(b) Medication Container</p> <p>NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is</p>	Y 923			

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